

which were successfully treated. On the 25th day of life, the newborn was transferred to the neurosurgical unit for reservoir implant, cerebrospinal fluid (CSF) drainage and further treatment. Due to the favorable evolution, after 20 days he was transferred back to the premature care unit.

**Conclusions.** Recognition of early signs of intraventricular hemorrhage with catastrophic or saltatory pattern, proper prenatal and neonatal care is essential in order to reduce mortality among preterm newborns.

**Key words:** intraventricular Hemorrhage, ventriculomegaly, preterm infants

## **15. CLINICAL MANAGEMENT IN PREGNANCY COMPLICATED WITH HELLP SYNDROME. CLINICAL CASE PRESENTATION**

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**Background.** Preeclampsia complicates 2-3% of all pregnancies (5-7% in nulliparous women) and remains a leading cause of maternal and perinatal mortality and morbidity. HELLP syndrome is a rare manifestation of hypertensive diseases of pregnancy and represents the most severe end of the pre-eclampsia spectrum. It occurs in 0.5 to 1% of all pregnancies and in 10-20% of cases with severe preeclampsia. Although variable, the onset of the HELLP syndrome is usually rapid.

**Case report.** Patient X, 31y.o, primigesta, 39 w.g. was admitted to the maternity unit complaining of amniotic fluid leakage. She was not in labor on admission and her vital signs were normal: blood pressure (BP) was 130/80 mm Hg, pulse - 76/min. Her antenatal history was uneventful before this admission. Physical examination revealed peripheral edema, pathological weight add + 17 kg. Vaginal delivery according to the protocol was established. Over one hour, suddenly, the patient accused pronounced epigastric pain, occipital headache associated with high BP 180/110 mm Hg. Laboratory investigations included: thrombocytopenia -  $120 \times 10^9$  g/l, leukocytosis -  $12.4 \times 10^9$ g/l. Liver function tests included increased concentrations of alkaline phosphatase - 126 u/l, LDH - 4886 u/l, ALAT - 317 u/l, ASAT - 500 u/l. Urinalysis for protein - 4.32 g/l. On the background of hypotensive therapy, the 150/100 mm Hg BP and symptoms of organ damage persisted. At this stage a diagnosis of HELLP syndrome was considered. In view of the rapid progression of the disease and the gestational age, it was decided to proceed to urgent delivery by caesarean section. One infant was delivered, with intrauterine growth restriction (weight - 2390g). In dynamics, hemolysis syndrome is also associated (haemoglobin - 90 g/l, erythrocytes -  $2.9 \times 10^{12}$ g/l, haematocrit - 0.27%). Postoperative period was complicated by CID syndrome and acute renal failure. Clinical management was performed according to the protocols and patient was discharged in satisfactory condition at 11th postpartum day.

**Conclusions.** HELLP syndrome is a severe complication of pregnancy, fulminant evolution being frequently evaluated in primiparous without pre-existing medical conditions. Due to maternal and fetal impact, HELLP syndrome needs an urgent delivery by caesarian section, which is the essential method indicated in the severe form.

**Key words:** HELLP syndrome, pregnancy.

## **16. MANAGEMENT OF GIANT OVARIAN CYST IN PREGNANCY. CLINICAL CASE REPORT**

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**Background.** Ovarian cysts are met in women of various ages, most commonly occurring during a woman's childbearing years, pregnant women not being an exception. Moreover, studies conclude that ovarian cancer is among top five types of cancers detected during pregnancy. The latest data show that the incidence of ovarian cysts in pregnancy varies from 0.15 to 5.7% malignancies ranging from 0.8 to 13%. Their evolution is frequently hard to predict, some cysts stop growing or disappear, while other may rupture, torsion or cause the obstruction of the delivery pathways. Only ovarian cysts at risk of complication are to be considered. These are mainly ovarian cysts, which, whatever their echogenic features, have a size  $\geq 5$  cm. Their prevalence is estimated between 0.5 and 2 per thousand of pregnancies.

**Case report.** Patient X, 21 y.o., primigesta, pregnant 36-37 w. a., underwent a routine gynecological and ultrasonographic examination, during which she was firstly diagnosed with a giant 195x115 mm cyst in the projection of the right adnexa, supposedly originating from the ovary. Considering the gestational term and the lack of data for cyst complications, an expectative management was chosen and a re-evaluation was scheduled in two weeks. Consequently, the woman was admitted to the IMSP IM and C 3rd level hospital for further monitoring, investigations and establishing the optimal birth management. The next performed USG showed that the dimensions of the cyst have grown to 223x123 mm, it was mainly situated in the subhepatic space, it's precise origin was hard to determine. It was decided to finish the pregnancy via caesarean section and invite a general surgeon to the intervention, in case other surgical manipulations would be needed. The tumoral markers were determined, with no deviations found: CA125 – 13,5 ( $N \leq 35$ ); HE4 – 35 ( $N \leq 70$ ); ROMA index – 3,4 ( $N 0 - 11,4\%$ ).

At the term of 38-39 w.a. an elective caesarean section was performed. It was established that the cyst had an ovarian origin and was fully extracted. The abdominal cavity was drained. Total haemorage-800 ml. The woman and the newborn were discharged home on the 4th postoperative day. The histological exam revealed an ovarian dymorphus sero-mucinous cystadenome, with a 2+ to 3+ mucin reaction, follicular cysts and lonely, distrofic primordial follicles.

**Conclusions.** Though ovarian cysts are seldom met in pregnancy, their presence may have serious repercussions on the evolution of the pregnancy and on the fetus. This is why, even in the absence of symptoms, an USG supervision combined with other methods for diagnostic is necessary. The decision upon the optimal birth way should be taken individually in each case, the histological exam being crucial for establishing the final diagnosis.

**Key words:** ovarian cyst, pregnancy

## DEPARTMENT OF INFECTIOUS DISEASES

### 17. DENGUE INFECTION: A CASE PRESENTATION

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**Background.** Dengue disease is an acute viral illness with the common symptoms, such as: high fever, muscle and joint pain, myalgia, cutaneous rash, hemorrhagic episodes. According to the WHO, the number of cases increased to 390 million per year in more than 100 countries, especially in the tropical and subtropical regions.